FINANCIAL POLICY

To help achieve our goal of providing the best medical care possible, we ask for your understanding and cooperation regarding the following payment/insurance policies:

Payments
We ask that payments, including any applicable deductible or copayment, be made at the time of service unless other arrangements have been made in advance. For your convenience, we accept cash, check, money orders, debit cards, and most credit cards.

Payment and Insurance
It is customary to pay for professional services when rendered. As a courtesy, we will bill your insurance company on your behalf. Your insurance is a contract between you and your insurance carrier. You will receive an explanation of benefits from them itemizing your responsibilities. You will be responsible for any co-payments, deductibles, or non-covered services as determined by your insurance company. Any balance remaining after your health plan pays will be due upon receipt of a statement.

If you have not met your deductible, you will be responsible for 100% of your visit.

If Eye Associates of Texas is not a participating provider in your insurance plan, you will be responsible for filing your own claims and will be responsible for paying in full at the time of service.

In accordance with our contract with your insurance provider, we are responsible for collecting, and you are responsible for paying, co-payments prior to your exam.

Eye Associates of Texas will verify your insurance eligibility prior to your appointment, however this is **not a guarantee of payment by your insurance company**.

If we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

The adult accompanying a minor and his/her parents (or guardian) are responsible for payment upon completion of your exam or consultation.

Patients with HMO or POS Insurance
If you are a member of an HMO or POS plan, you need to have a valid referral from your primary medical doctor for each office visit and surgical procedure. Prior to your visit, please call in advance to ensure that all necessary forms and authorizations are in place. Without a valid referral, financial responsibility will lie upon the patient.

Refraction Charge
For patients whose insurance does not cover refractions, we ask that payments be made at the time the new prescription for eyeglasses is dispensed. All requests for re-refraction must be requested within 30 days or repeat charge will be issued.

Optical Warranty
A warranty will be available for purchase when at the time of sale of glasses. An optical warranty will cover 2 remakes over the span of 1 year with applicable copay and charges.

Medical Records Release
There is a $35 fee for all medical records release. However access to the patient portal with ability to view personal medical records electronically will be provided to all patients, free of charge.

Late Payments
It is our policy to render periodic statements for services on a monthly basis. We reserve the right, at our option, to charge interest on outstanding balances beyond 60 days at a rate of 5% per month.

Returned Checks
Returned checks will incur an additional $35 fee. **Payment by check for all surgical procedures must be made a minimum of 7 days prior to surgery.**

Assignment of Benefits
I hereby authorize Eye Associates of Texas, its Doctors, and/or agents to apply for reimbursement benefits on my behalf for services rendered to me. I understand that payment from my insurance carrier will be made directly to Eye Associates of Texas. I further authorize the release of any information necessary to process any claim with my insurance carrier. I understand that I am financial responsible for all charges, including those not covered by my health insurance. I further understand that I will be responsible to pay for any service denied by my insurance company.

Patients Receiving Specialized Services and/or Procedures
As a courtesy to me, Eye Associates of Texas has obtained information regarding specific benefits covered and payable under my health insurance plan from a representative of my health insurance company and has explained those benefits to me. I understand that Eye Associates of Texas has acted in good faith in this effort and that the benefit information provided to Eye Associates of Texas by my health insurance company may not be accurate.

I acknowledge that the benefit information obtained by Eye Associates of Texas on my behalf was qualified by a representative of my health insurance company with the following statements:

1) This is an estimate of the benefits provided under the patient's insurance contract:
2) Any payment is subject to the coordination of benefits with any other insurance that may cover the services rendered and the coverage being in effect on the date of service;

3) Verification of eligibility or benefits is **not a guarantee of coverage** or payment and is subject to any policy provisions and exclusions that are in effect at the time services are rendered.

If medical Insurance benefits DO NOT cover Refractive visits. There will be a charge for each test in addition to Copays and Charges for all exams.

Late Payment

It is Eye Associates of Texas' policy to render periodic statements for services. We reserve the right, at our option, to charge interest on outstanding balances. All past due balances will be sent over to a collection agency. By signing this acknowledgement form you agree that if your account is sent to an attorney or collection agency for collection, you will pay collection expenses and reasonable attorney's fees as established by the court and not by a jury in any court action. You understand and agree that if your account is delinquent, you may be charged interest at the legal rate. Any benefits of any type under any policy of insurance, insuring the patient, or any other party liable to the patient, is hereby assigned to Eye Associates of Texas. If copayments and/or deductibles are designated by my insurance company or health plan, you agree to pay them to Eye Associates of Texas.

By signing the acknowledgment form, I attest that I have read and understand the payment policy and agree to abide by its guidelines.